

# HOSPITAL ACUTE INPATIENT SERVICES PAYMENT SYSTEM

payment**basics**

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Medicare beneficiaries enrolled in the traditional fee-for-service program receive care in over 3,200 facilities that contract with Medicare to provide acute inpatient care and agree to accept the program's predetermined payment rates as payment in full.<sup>1</sup> Payments made under the acute inpatient prospective payment system (IPPS) totaled \$118 billion and accounted for about 17 percent of Medicare spending in 2017. (Over 1,300 rural hospitals qualify as critical access hospitals and are paid on a cost basis instead of under the IPPS. The *Critical Access Hospitals Payment System* document in our "Payment Basics" series provides more information on this topic.)

Medicare's inpatient hospital benefit covers beneficiaries for 90 days of care per episode of illness, with a 60-day lifetime reserve. Illness episodes begin when beneficiaries are admitted and end after they have been out of the hospital or a skilled nursing facility for 60 consecutive days. In 2019, beneficiaries are liable for a deductible of \$1,364 for the first hospital stay in an episode, and daily copayments—currently \$341—are imposed on the 61st to 90th day. For episodes longer than 90 days, beneficiaries are liable for a \$682 daily copayment for each lifetime reserve day and all costs for days once lifetime reserve days have been exhausted.

## Defining the inpatient acute care products Medicare buys

The IPPS primarily pays per discharge rates covering operating and capital expenses. The payment rates are intended to cover the costs that reasonably efficient providers would incur in furnishing high-quality care.

To account for the patient's needs, Medicare assigns discharges to Medicare severity diagnosis related groups (MS-DRGs), which are based on patients' clinical conditions and treatment strategies.

Clinical conditions are defined by both the patients' discharge diagnoses, including the principal diagnosis—the main problem requiring inpatient care—and up to eight secondary diagnoses indicating other conditions that were present at admission (comorbidities) or developed during the hospital stay (complications). The treatment strategy—surgical or medical—is defined by the presence or absence of up to six procedures performed during the stay.

The MS-DRG system has 335 base DRGs, most of which are split into 2 or 3 MS-DRGs based on the presence of either a comorbidity or complication (CC) or major CC. Discharge destination and use of a specific drug are occasionally used along with principal diagnosis and procedures in structuring base DRGs. There are 759 MS-DRGs in 2020.

Each MS-DRG has a relative weight that reflects the expected relative costliness of inpatient treatment for patients in that group. CMS annually reviews the MS-DRG definitions to ensure that each group continues to include cases with clinically similar conditions requiring comparable amounts of inpatient resources. When the review shows that subsets of clinically similar cases within an MS-DRG consume significantly different amounts of resources, CMS often reassigns them to a different MS-DRG with comparable resource use or creates a new MS-DRG.

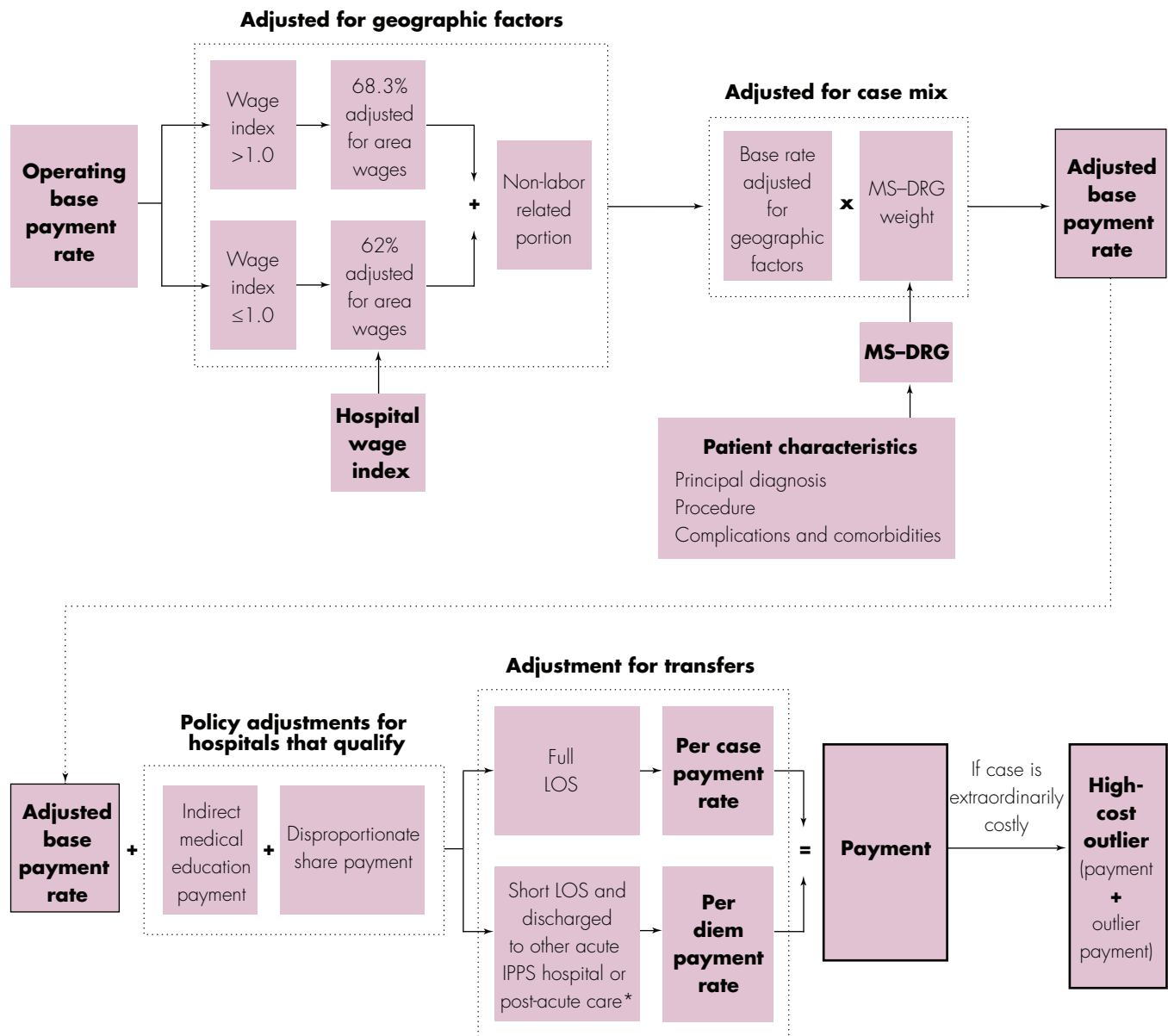
Facing fixed payment rates, providers have financial incentives to reduce their inpatient costs by moving some services to another setting. Medicare has adopted policies to counter these incentives. Thus, related outpatient department services delivered in the three days before admission are included in the payment for the inpatient stay and may not be separately billed (referred to as the 72-hour rule). Similarly, payment is reduced when patients have a short length of stay and are

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**Figure 1 Acute inpatient prospective payment system for fiscal year 2020**



Note: MS-DRG (Medicare severity diagnosis related group), LOS (length of stay), IPPS (inpatient prospective payment system). Capital payments are determined by a similar system. In addition to the inpatient operating and inpatient capital payments per discharge, hospitals may receive additional payments, such as those related to direct graduate medical education, uncompensated care, and bad debts. Additional payments are also made for certain rural hospitals. Hospitals may receive penalties or additional payments based on their performance on quality standards.

\* Transfer policy for cases discharged to post-acute care settings applies for cases in 278 selected MS-DRGs.

transferred to another acute care hospital or, in many MS-DRGs, when patients are discharged to post-acute care settings.

### Setting the payment rates

Medicare's per discharge payments are derived through a series of adjustments

applied to separate operating and capital base payment rates (Figure 1). The two base rates are updated annually and are adjusted to reflect patient conditions, market conditions, and other factors recognized under Medicare's payment system. In 2020, the operating base rate update is 2.6 percent. The update is the

sum of the hospital market basket (which measures the price increase of goods and services hospitals buy to produce patient care) of 3.0 percent, less the current 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity of 0.4 percentage points. Hospitals that fail to provide data on specified quality indicators or be meaningful users of electronic health records only receive a fraction of the market basket update. The Secretary determines the update to the capital payment rate. Both operating and capital base rates are also updated based on budget neutrality adjustments.

Certain costs are excluded from the per discharge payments and paid separately, such as the direct costs of operating graduate medical education programs, organ acquisition costs, and the cost of providing uncompensated care.

**The base payment amounts** Medicare sets operating and capital per discharge base rates (known as standardized payment amounts). Operating payments are tied to labor and supply costs; capital payments are tied to costs for depreciation, interest, rent, and property-related insurance and taxes. For fiscal year 2020, the operating base rate is \$5,797. The capital rate is \$462.

#### **Adjustment for geographic factors**

Medicare's base operating and capital rates are adjusted by an area wage index to reflect the expected differences in local market prices for labor.<sup>2</sup> The wage index is intended to measure differences in hospital wage rates among labor markets; it compares the average hourly wage for hospital workers in each metropolitan statistical area or statewide rural area to the nationwide average, after controlling for differences in hospitals' occupational mix. The wage index is revised each year based on wage data reported by IPPS hospitals.

The wage index is applied to the labor-related portion of the base rate (usually called the "labor share"), which reflects an estimate of the portion of costs affected by local wage rates and fringe benefits. CMS's current operating labor share estimate of

68.3 percent is applied to hospitals with a wage index above 1.0. The Congress has legislated an operating labor share of 62 percent for hospitals located in areas with a wage index less than or equal to 1.0.

**Adjustment for case mix** The wage-adjusted operating and capital rates are then adjusted for case mix using a MS-DRG weight that reflects the patient's condition and expected costliness.

**Medical education payments** Teaching hospitals receive add-on payments to reflect the additional (indirect) costs of patient care associated with resident training.

The size of the indirect medical education (IME) adjustment depends on the hospital's teaching intensity. For operating payments, teaching intensity is measured by a hospital's allowed number of residents per inpatient bed.

For fiscal year 2020, the operating IME adjustment increases the IME percentage add-on to base payment by up to 5.5 percentage points for every 0.1 increase in a hospital's resident-to-bed ratio.

Medicare pays separately for the direct costs of operating approved training programs for medical, osteopathic, dental, or podiatric residents. These graduate medical education (GME) payments are based on hospital-specific costs per resident in a base year, the number of allowed residents, and Medicare's share of inpatient days.

**Disproportionate share and uncompensated care payments** Hospitals that treat a disproportionate share (DSH) of certain low-income patients receive additional operating and capital payments thought to offset the financial effects of these patients.

Beginning in 2014, each hospital receives (1) a reduced operating DSH payment and (2) an uncompensated care payment. Under the revised operating DSH payment equation, hospitals will receive 25 percent of the DSH funds they would have received under prior law. Here, a hospital's low-

income patient share is the sum of the proportion of its Medicare inpatient days provided to patients eligible for Supplemental Security Income benefits and the proportion of its total acute inpatient days furnished to Medicaid patients. Any hospital with a low-income share exceeding 15 percent is eligible to receive operating DSH payments based on a complex formula. However, the add-on rate is capped at 12 percent of base inpatient payments for most rural hospitals and urban facilities with fewer than 100 beds.<sup>3</sup>

Second, pursuant to a provision in the Patient Protection and Affordable Care Act of 2010 (PPACA), each hospital will receive uncompensated care payments equal to its share of a fixed pool of dollars defined as 75 percent of estimated aggregated operating DSH payments under the prior law DSH formula multiplied by the national uninsured rate as a percentage of the uninsured rate in 2013. This is referred to as the uncompensated care pool. In fiscal year 2020, the uncompensated care pool will be allocated to hospitals based on their share of reported uncompensated care costs in 2015 relative to all other hospitals receiving DSH payments. CMS projects the uninsured rate in 2020 to be 67 percent of the rate in 2013 and has therefore set the 2020 uncompensated care pool at \$8.4 billion dollars.

The capital DSH payments are based completely on the prior law DSH formula and do not include a component based on uncompensated care. Capital DSH also only applies to urban hospitals with 100 or more beds and that serve low-income patients.

**Transfer policy** Medicare reduces MS-DRG payments when patients:

- have a length of stay at least one day less than the geometric mean length of stay for the MS-DRG,<sup>4</sup>
- and are either transferred to another hospital covered by the acute inpatient PPS or designated as a critical access hospital, or are in one of 278 MS-DRGs and discharged to a post-acute care setting.

The post-acute settings covered by the transfer policy include long-term care hospitals; rehabilitation, psychiatric or skilled nursing facilities; hospice care; and home health care if the patients receive clinically related care that begins within three days after the hospital stay.

Transferring facilities under this policy are paid a per diem rate rather than the full MS-DRG payment. Generally, hospitals receive twice the per diem rate for the first day and the per diem rate for each additional day.<sup>5</sup>

**New technology payments** Hospitals with cases treated using certain cost-increasing technologies receive add-on payments for new technologies. CMS evaluates applications by technology firms and others for add-on payments based on criteria of newness, substantial clinical improvement, and the costliness of the technology beyond the level of the current MS-DRG payment amount. New technology payments are additional to the MS-DRG payment and thus are not budget neutral.

**Outlier payments** Some cases are extraordinarily costly, producing losses that may be too large for hospitals to offset. Medicare makes extra payments for these so-called outlier cases, in addition to the usual operating and capital MS-DRG payments.

Outlier cases are identified by comparing the cost of that case to an MS-DRG-specific threshold that is the sum of the hospital's:

- MS-DRG payment for the case (both operating and capital),
- any IME, DSH, and new technology payments, and
- a fixed loss amount.

CMS sets a national fixed loss amount (\$26,552 for fiscal year 2020), which is adjusted to reflect input price levels in the hospital's local market. Outlier payments are financed by prospective offsetting reductions in the operating base rate (5.1 percent) and the capital base rate (5.4 percent). CMS sets the national fixed loss amount at the level it estimates will result

in outlier payments equaling the offset. Medicare pays 80 percent of hospitals' costs above their fixed loss thresholds for most DRGs.

### **Special payments for rural hospitals**

**Sole community hospital payments**—Medicare makes additional payments to certain rural hospitals, although some urban facilities also may qualify. Hospitals that are located at least 35 miles from the nearest like hospital (excluding CAHs and Indian Health Service hospitals)—or that are located in a rural area and meet criteria related to isolation—are eligible for the sole community hospital (SCH) program. These facilities receive operating payments equal to the higher of payments under the IPPS or payments based on their costs per discharge in a base year updated to the current year and adjusted for their current year case mix.

**Medicare-dependent hospital payments**—The Medicare-dependent hospital (MDH) program is for small rural hospitals in which Medicare patients comprise at least 60 percent of their admissions or patient days. These hospitals receive operating payments equal to IPPS payments plus 75 percent of the difference between those payments and payments based on their updated base-year costs.

**Low-volume hospital payments**—For fiscal year 2020, hospitals receive an additional payment if they qualify as a low-volume facility. Low-volume facilities are defined based on their total number of discharges (fewer than 3,800 discharges) and are required to be located more than 15 miles from the nearest like hospital. The add-on payment these facilities receive is up to 25 percent on top of their prospective payment rate, varying by their volume of total discharges.<sup>6</sup>

### **Quality incentive payments and penalties**

**Excess readmissions penalty**—As required by PPACA, the hospital readmission reduction program was implemented in fiscal year 2013. As a part of this program, hospitals that have excess Medicare readmissions for selected conditions will have their

IPPS payments reduced. In fiscal year 2020, the readmissions policy applies to six conditions (acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, total hip and knee arthroplasty, and coronary artery bypass graft). Hospitals whose Medicare risk-adjusted readmission rates are greater than the national average rates will have their IPPS payments reduced. In 2020, the payment penalty is capped at 3 percent of a hospital's base DRG payments per year.

**Value-based incentive payments**—As mandated by PPACA, the value-based incentive payment program was implemented in fiscal year 2013. As a part of the program, CMS redistributes a pool of dollars equal to 2 percent of base inpatient DRG payments. As a part of the program, CMS redistributes a pool of dollars equal to 2 percent of base inpatient DRG payments based on performance on a set of outcome, patient experience, safety, and efficiency measures.

**Hospital-acquired conditions penalty**—As required by PPACA, the hospital-acquired condition reduction program was implemented in 2014. Hospitals are ranked on their total rate of preventable conditions such as falls, surgical site infections, and catheter-associated urinary tract infections. The 25 percent of hospitals with the highest rates of preventable conditions receive a 1 percent reduction in all inpatient payments.

**Bad debt payments** Medicare reimburses acute-care hospitals for 65 percent of bad debts resulting from beneficiaries' nonpayment of deductibles and copayments after providers have made reasonable efforts to collect the unpaid amounts. ■

- 1 Medicare pays the approved amount minus any beneficiary liability, such as a deductible or copayment; the provider then collects the remaining amount from the beneficiary or a supplemental insurer.
- 2 A hospital may request geographic reclassification to an adjacent market area for its wage index. Roughly one-quarter of hospitals were approved for reclassification in 2020. To qualify, a hospital must demonstrate proximity (location within 15 miles of the border of



the adjacent area for urban hospitals and 35 miles for rural hospitals) or at least 50 percent of the hospital's employees must reside in the adjacent area. It also must show that its hourly wages are above average for its market area (above 106 percent for rural hospitals and 108 percent for urban hospitals) and comparable to wages in the area to which it seeks reclassification (at least 82 percent of that area's average for rural hospitals and 84 percent for urban hospitals). Certain large rural hospitals and hospitals that are the dominating or sole hospital in an area are exempt from the wage-related criteria, and hospitals in a county applying as a group are subject to different wage criteria. In addition, hospitals can seek reclassification from urban to rural areas.

- 3 The 12 percent cap does not apply to rural facilities with at least 500 beds, rural referral centers, or Medicare-dependent hospitals. An add-on of 35 percent of base inpatient payments is available for urban hospitals with at least 100 beds that receive at least 30 percent of their inpatient revenue (excluding Medicare and Medicaid) from state and local government subsidies. These are referred to as "Pickle" hospitals.

- 4 A geometric mean gives less weight to unusually long lengths of stay than an arithmetic mean, thus producing a lower estimate of the average length of stay and fewer cases affected by the transfer policy.
- 5 An exception exists for certain MS-DRGs with high first-day costs. These transfer cases are paid half the full MS-DRG payment plus one per diem payment and half the per diem rate for subsequent days.
- 6 Hospitals with 500 or fewer total discharges receive a flat 25 percent add-on payment. Hospitals with between 501 and 3,799 total discharges receive an add-on payment on a continuous sliding scale between 0.008 and 25 percent derived from the relative proportion of payments associated with their volume of total discharges. In 2023, the low-volume hospital payment formula is set to revert to the prior formula which was based on Medicare, not total, discharges.